

# INSTITUTIONAL SPECIAL NEEDS PLAN (I-SNP): ANNUAL MODEL OF CARE TRAINING



# OVERVIEW

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- Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care (MOC)
- Information about the program must be available for submission to CMS or for review during monitoring visits
- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for providers
- Purpose of this training is to comply with the statutory requirement of CMS that all SNPs provide a general understanding of the requirements of the MOC



# OBJECTIVES

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REVIEW I-SNP  
ELIGIBILITY



DEFINE THE MODEL OF  
CARE



REVIEW THE ELEMENTS  
OF THE MODEL OF  
CARE



# INSTITUTIONAL SPECIAL NEEDS PLANS (I-SNPS)

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I-SNPs restrict enrollment to Medicare Advantage (MA) eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a:

- **Skilled nursing facility (SNF)#**
- **LTC nursing facility (NF)#**
- Assisted living facility (ALF)
- Intermediate care facility for the mentally retarded (ICF/MR)
- Inpatient psychiatric facility

**#Longevity Health Plan enrolls on Long Term residents of a nursing facility**



# WHO CAN JOIN AN I-SNP?

- Entitled to Medicare Part A (Hospital Insurance)
- Enrolled in Medicare Part B (Medical Insurance)
- Live in Plan service area
- Do not have End-Stage Renal Disease (ESRD) at enrollment
- Must reside, or be expected to reside, in a participating I-SNP Plan facility for greater than 90 days at time of enrollment



# WHAT IS A MODEL OF CARE (MOC)?

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I-SNP MOC is the Plan's detailed, written commitment to CMS on how we will provide care to enrolled Members. It is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed.

## **How We Care For Our Members:**

- MOC is designed to maintain our Members at an optimal level of function
- Reduce non-essential hospital admissions when care can safely be provided in the Plan facility
  - Focus on prevention:
    - Regular visits
    - Care Protocols
  - Goals to improve:
    - Avoidable hospitalizations
    - ER Visits
    - SNF
    - Unnecessary Specialist Visits



# ELEMENTS OF THE MOC

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**MOC 1:** Description of the I-SNP Population

**MOC 2:** Care Coordination

- SNP Staffing Structure
- Health Risk Assessment Tool (HRAT)
- The Individualized Plan of Care (IPOC)
- The Interdisciplinary Care Team (ICT)
- Care Transition Protocol

**MOC 3:** Provider Network

**MOC 4:** Quality Measurement & Performance Improvement



# MOC 1:

## TARGET POPULATION

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- Institutionalized Medicare beneficiary who resides or is expected to reside in a Plan contracted nursing facility for 90 days or longer
- Frail / vulnerable
- More likely to be female
- Average age is 85 years old
- Typically widowed or single
- Primarily Caucasian
- English-speaking
- Often unable to make care decisions and participate in their own care
- May be confined to a bed or wheelchair
- Has multiple co-morbid chronic conditions (e.g. high blood pressure, heart disease, depression, diabetes, COPD)
- Likely prescribed one or more high-risk medications per month
- Needs help with 5 or more activities of daily living (ADLs) including bed, mobility, dressing, eating and toileting
- High likelihood of reporting daily pain
- Has moderate to severe cognitive impairment
- Overall low health literacy
- Has socioeconomic issues creating barriers to care
- Lacks consistent, engaged caregiver / family support



# MOC 2: CARE COORDINATION STAFFING

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# STAFFING MODEL

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- All Members are required to choose a primary care physician for their onsite primary care services
- PCP/Nfists care driven model with dedicated medical providers physically located at the contracted nursing facilities to enhance and provide bedside care management and coordination
- Supported by Plan Provider (PP)- Nurse Practitioner
- On-site primary care support
  - Access to the Member's facility record, and along with initial risk assessment tools, MDS information and a full history and physical
  - Primary point of contact for comprehensive assessments, IPOC, ICT, and Member care transitions
  - Centralized point of contact for Members and families/caregivers
  - 24/7 access to Plan Provider Nurse Practitioner



# MOC 2:

## HEALTH RISK ASSESSMENT TOOL (HRAT)

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- As an Institutional Special Needs Plan, the Plan will utilize the HRAT that is comprehensive, specialized for institutional patients, and administered in person as the **starting point** for all care coordination activities on behalf of the Plan.
- The main objective of the Health Risk Assessment (HRA) will be to assess the Member's current health status, estimate their level of health risk, and to facilitate the development of their Individualized Plan of Care (IPOC).
- The Plan Provider utilize a risk assessment tool that rates each Member's acuity and medical needs:
  - Low risk
  - Moderate risk
  - High risk
- Risk score dictates the Plan Provider's visit schedule
- Risk score framework used at each visit and tracked over time via encounter data



# MOC 2:

## INDIVIDUALIZED PLAN OF CARE (IPOC)

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- Member-centered
  - The Member or representative is encouraged to be part of this development and voice preferences for clinical and social interventions
- Includes problem, goals, and interventions
- Individualized for each Member
- Reviewed with interdisciplinary care team
- Maintained electronically in the Plan's Documentation System (PDS)
- Evaluated and updated on a quarterly basis or when a significant change in condition or status is identified



## MOC 2: INTERDISCIPLINARY CARE TEAM (ICT)

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- Developed to ensure effective coordination of care
- Composition varies and is dependent on each Member's unique circumstances, risk-level, and individual needs and preferences
- Includes Member and representative(s)
- Plan Provider leads the ICT
- Regular communications
- Continuous monitoring
- Meets quarterly, at a minimum, to review Member goals



# MOC 2:

## CARE TRANSITION PROCESS

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- The Plan Provider, PCP and Member's family/caregiver notified of every acute care transition
- Prior to Member's transition, the facility completes a checklist/packet that includes:
  - Member's comprehensive history and physical notes
  - Most recent comprehensive or episodic note
  - Consult notes
  - Medication list
  - Advanced directives
- The Plan Provider is responsible for coordinating the care transition process
  - POC for communication with the Member, their caregiver/family, the doctors, and nursing staff
- Upon return to the Plan facility, the Plan Provider must initiate follow up with the Member, within 48 hours
  - Comprehensive assessment conducted; discharge summary reviewed and signed; medication reconciliation performed; care plan updated, if applicable
- The Plan Provider updates the ICT on the Member's status and transition plan



# MOC 3:

## PROVIDER NETWORK

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- The Plan provides network of providers, specialists, and facilities with specialized expertise pertinent to the care and treatment of its Members
- Evaluates provider adequacy with sufficient number of professionals to provide services directly on the premises of the Plan facility such as:
  - Board Certified specialists - Geriatrics, Cardiology, Neurology, Nephrology, Pulmonology, Endocrinology, Orthopedics, Behavioral Health
  - Clinicians - Nurse Practitioners, Physical Therapists, Occupational Therapists, Respiratory Therapists
  - Inpatient facilities - Acute Hospitals and Rehabilitation and Psychiatric



# MOC 3:

## CLINICAL PRACTICE GUIDELINE COMPLIANCE

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- Clinical Guidelines Committee evaluates and adopts clinical practice guidelines applicable to the needs of the Plan's membership
- Annually, the Plan will review compliance with selected clinical practice guidelines through data analysis
- When guidelines are not satisfactorily adhered to by individual network providers, the Plan will intervene with the provider
- When a systemic problem is identified, the Plan will undertake broader educational efforts with the network and then evaluate through additional data analysis



# MOC 4:

## QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

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- The purpose of the Quality Improvement Program (QIP) at the Plan will be to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its Members, partners, and other stakeholders so that the Plan may fully realize its vision, mission and commitment to Member care.
- Continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services
- All data analysis and standard reporting is used in the Annual Quality Improvement work plan
  - Presented to the Board of Directors for their review and approval
- Elements reflecting Plan performance are shared across the Plan and with key Providers
- The Plan educates its network and membership with updates regarding performance measures and/or changes in the MOC
- High-volume physicians receive reports on individual performance against expectations and benchmarks



# MOC COMPLIANCE

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Who is Responsible for compliance with the MOC?

**Everyone!**

Compliance with CMS requirements and the ethical administration of the Plan's I-SNP MOC is an enterprise-wide, shared responsibility.

